MODULE V: LEVEL I SCREEN
FOR MENTAL ILLNESS/MENTAL RETARDATION

Agency Name and Address: _____

IDENTIFICATION AND BACKGROUN INFORMATION

1.	APPLICANT NAME	First: _____ (MI) _____ Last: _____	7.	EMERGENCY CONTACT: Name: _____ Address: _____ _____ Relationship: _____ Telephone: _____ Legal Guardian: ☐Yes ☐No
2.	ADDRESS:	Street: _____ City/Town: _____ County: _____ State: _____ ZIP: _____ Phone: (___) _____.	8.	CONTINUING PHYSICIAN Address: _____ _____ Telephone: _____
3.	SOCIAL SECURITY NO:	☐☐☐-☐☐-☐☐☐☐		
4.	MEDICAID NO. (if applicable)	☐☐☐☐☐☐☐☐☐☐	9.	Name & Address of Nursing Facility: Name: _____ Address: _____
5.	MEDICARE NO. (if applicable)	☐☐☐☐☐☐☐☐☐☐☐☐		
6.	BIRTH DATE	☐☐-☐☐-☐☐☐☐ Month Day Year	10.	Estimated length of stay _____ days Has physician documented that this applicant's stay in a NF will be 30 days or less? ☐Yes ☐No

MODULE V: MENTAL ILLNESS/MENTAL RETARDATION NURSING FACILITY LEVEL I SCREEN

1. Does the individual have a major mental illness diagnosis? ☐Yes - Proceed with Question 2 ☐No – Go to Question 5
2. Diagnosis (Dx) _____ DSM Code: ☐☐☐-☐☐
3. Has the diagnosis resulted in functional impairment in the past 6 months, such as:
   a. Inability to communicate effectively with others ☐Yes ☐No
   b. Inability to complete simple tasks unassisted ☐Yes ☐No
   c. Serious difficulty interacting with others appropriately ☐Yes ☐No
   d. Danger to self or others, aggressive, assaultive, suicidal ☐Yes ☐No

   TOTAL # _____YES
4. Did the individual have any intervention due to a mental illness in the past two years, such as:
   a. Hospitalization for psychiatric care ☐Yes ☐No
   b. Supportive services at home ☐Yes ☐No
   c. Housing/law enforcement intervention ☐Yes ☐No
   d. Residential treatment ☐Yes ☐No

   TOTAL # _____YES

Questions 1&3&4 must each have one "YES" answer to meet PASARR criteria for diagnosis of mental illness
If yes Mental Illness, FAX TO: *REGION 1 822-0295 (fax) 822-0270 (phone)
*REGION II 287-9152 (fax) 287-9170 (phone) REGION III 941-4343 (fax) 941-4773 (phone)

IF NO MENTAL ILLNESS: SEND COPY OF THIS FORM TO NURSING FACILITY

5. Does the individual present evidence of diagnosis and/or documented mental retardation? (Check one) ☐Yes ☐No

IDENTIFICATION OF MENTAL RETARDATION: Significant sub average general intellectual functioning existing chronic disabilities resulting in impairment of general intellectual functioning or adaptive behavior, manifested before the 22nd birthday, likely to continue indefinitely and resulting in substantial functional limitations.

IF YES MENTAL RETARDATION, FAX TO: *REGION 1 822-0295(fax) 822-0270(phone)
*REGION 2: Augusta 287-7186(fax) 287-2205(phone) Lewiston 782-1753(fax) 753-9100(phone) Thomaston 596-2304(fax) 596-2300(phone)
*REGION 3: Bangor 941-4389(fax) 941-4360(phone) Aroostook: 764-2001(fax) 554-2100

IF NO MENTAL RETARDATION: SEND COPY OF THIS FORM TO NURSING FACILITY

*__Note__: Regional office areas are by counties: REGION I – Cumberland & York REGION II – Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, and Waldo REGION III – Aroostook, Hancock, Penobscot, Piscataquis and Washington

IF ANSWERS TO THE ABOVE QUESTIONS 1-5 ARE ALL "NO", A COPY OF THIS FORM MUST BE SENT TO THE NURSING FACILITY.

_____ _____ _____ _____
Signature/Title Date Telephone # Fax #

Any decision for a Level II Assessment or deferral/waiver of a Level II Assessment be made by the Department of Health & Human Services

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